12-014.03B1 In-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined, facility staff shall (see 471 NAC 12-007) -

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.02C (the facility is responsible for verifying the client's Medicaid eligibility before completion of the MC-9-NF);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1; and
4. Submit all information to the Central office.

Facility staff must make a comprehensive assessment of the resident's needs within 14 days of admission using the Minimum Data Set (MDS) 2.0, and transmit it electronically to the Central Office in accordance with 42 CFR 483.20.

The HHSS review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time limited.

12-014.03B2 Out-of-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined, facility staff shall (see 471 NAC 12-007) -

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C (the facility is responsible for verifying the client's Medicaid eligibility prior to completion of the MC-9-NF);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1 (where applicable);
4. Attach a copy of their state-approved MDS; and
5. Submit all information to the Central Office.

The HHSS review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.

12-014.04 Utilization Review: HHSS will review records and programs established for authorized Medicaid client stays in a Special Needs program on a quarterly basis. These reviews can be conducted on-site or by submitting requested documentation to the HHSS. Upon completion of the utilization review, HHSS may determine that a client no longer meets the criteria as established in 471 NAC 12-014.01. The HHSS will notify the facility in writing of this finding. Examples of conditions for termination of special needs payment include but are not limited to:

1. The client has medically, physically, or psychologically regressed and cannot participate in the established program documented for at least one month duration;
2. The client refuses to participate in the established program for a documented time of at least one month;
3. The client no longer has documented progress toward established program goals and/or the client's progress has reached a plateau with no documented progress for at least three months (maintenance goals do not qualify the client to continue the program);
4. The client no longer meets criteria as defined in 471 NAC 12-014 that pertains to his/her specific program needs (for example, ventilator use, complex care needs are resolved, pediatric client turns 22).

12-014.04A Comprehensive Plan of Care: The facility shall submit copies of the initial comprehensive plan of care and subsequent interdisciplinary team meetings (see 471 NAC 12-014.02, item 9e) that document the client's progress/lack of progress toward the client's established program outcomes/goals to the Medicaid Central Office quarterly.

12-014.04B: NMAP will require monthly reviews for extended brain injury rehabilitation stays beyond two years.

12-014.04C Right to Contest a Decision: See 471 NAC 2-003.01.

12-014.05 Payment for Services for Long Term Clients with Special Needs: Payment for services to all special needs clients shall be prior authorized by Department staff in the Central Office.

12-014.05A Nebraska Facilities: To establish a Nebraska facility's payment rate for care of special needs clients -

1. The facility shall submit Form FA-66, "Long Term Care Cost Report," to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with 471 NAC 12-012, Completion of Form FA-66, "Long Term Care Cost Report," and 471 NAC 12-011 ff., Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM-15). If the facility provides both nursing facility services and special needs services, direct accounting and/or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department of Health and Human Services Finance and Support Long Term Care Audit Unit.
2. The Department shall compute the allowable cost per day from Form FA-66 or the Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated, effective for the following calendar year rate period. Negotiations may include, but are not limited to, discussion of appropriate inflation/deflation expectations for the rate period and significant increases/decreases in the cost of providing services that are not reflected in the applicable cost report. The cost of services generally included in the allowable per diem include, but are not limited to -
   a. Room and board;
   b. Preadmission and admission assessments;
   c. All direct and indirect nursing services;
   d. All nursing supplies, to include trach tube and related trach care supplies, catheters, etc.;
   e. All routine equipment, to include suction machine, IV poles, etc.;
   f. Oxygen and related supplies;
   g. Psycho-social services;
   h. Therapeutic recreational services;
   j. Administrative costs;
   k. Plant operations;
   l. Laundry and linen supplies;
   m. Dietary services, to include tube feeding supplies and pumps;
   n. Housekeeping; and
   o. Medical records.

Services not commonly included in the per diem (unless specifically provided via the facility's contract) include, but are not limited to -

a. Speech therapy;
b. Occupational therapy;
c. Physical therapy;
d. Pharmacy;
e. Audiological services;
f. Laboratory services;
g. X-ray services;
h. Physician services; and
j. Dental services;

These services are reimburse under the Department's established guidelines. Costs of services and items which are covered under Medicare Part B for Medicare-eligible clients must be identified as an unallowable cost.

3. If the facility has no prior cost experience in providing special needs services, the facility shall submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience.
4. An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities;
5. After a rate is agreed upon, the Department and the provider shall enter into a contract. The contract, written by the Department, must include -
   a. The rate and its applicable dates;
   b. A description of the criteria for care;
   c. A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately; and

d. Other applicable requirements that are necessary to be included in all Department contracts.
The contract must be signed by both parties before payments may be made for any services provided by the facility.

6. In lieu of the rate establishment procedure described in this section and under mutual agreement of both the provider and the Department, a multi-year contractual arrangement may be entered into by the parties. Reimbursement shall reflect the facility's actual reasonable cost of providing services to special needs clients and shall be updated annually using an appropriate inflation adjustment.

12-014.05B Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the establishment of the Nebraska Medicaid provider agreement. The payment is not subject to any type of adjustment.

12-014.05C Payment for Bed-Hold: Payment for bed-hold for hospitalization and/or therapeutic leave shall be as defined in 471 NAC 12-009.07.

12-014.06: The requirements of 471 NAC 12 apply to services provided under 471 NAC 12-014 unless otherwise specified in 471 NAC 12-014.